Texas Department of Health
Bureau of HIV and STD Prevention
Memorandum

To: Contractors for Early Access to Clinical and Preventive Services for Persons with HIV Disease

From: Debra Seaman, MSN, RN
Assistant Director
Clinical Resources Division

Date: February 28, 2003

Subject: **Renewal of Contracts for the term September 1, 2003 to August 31, 2004**

Enclosed is your application and instructions for renewal funding for the Early Access to Clinical and Preventive Services for Persons with HIV Disease, which is due for submission on April 28, 2003. Budgets should be submitted for level funding amounts, as shown on the table included with this memorandum; however contractors should be aware that contract renewal is contingent upon the continued availability of funding to TDH.

If you have questions regarding the renewal application, please contact me at 512/490-2505, extension 2629.

Enclosures

LEVEL FUNDING AMOUNTS EARLY ACCESS TO CLINICAL AND PREVENTIVE SERVICES FOR PERSONS WITH HIV DISEASE For the Project Period September 1, 2003 to August 31, 2004*	
Fort Bend Family Health Center, Inc. Richmond, Texas	$65,419
Health Horizons of East Texas, Inc. Nacogdoches, Texas	$110,000
Planned Parenthood Center of El Paso, Inc. El Paso, Texas	$110,000
San Angelo AIDS Foundation, Inc. San Angelo, Texas	$110,000
Smith County Public Health District Tyler, Texas	$81,500
Special Health Resources for Texas, Inc. Longview, Texas	$110,000
Triangle AIDS Network Beaumont, Texas	$95,451
Wichita Falls-Wichita County Public Health District, Wichita Falls, Texas	$101,015

* The Texas Department of Health (TDH) reserves the right to negotiate any terms and conditions including budget amounts and allocations. Any contract renewal is contingent upon the continued availability of funding to TDH.

Renewal Application Early Access to Clinical and Preventive Services for Persons with HIV Disease

Budget Period September 1, 2003 to August 31, 2004
Issued February 28, 2003

Bureau of HIV and STD Prevention
www.tdh.state.tx.us/hivstd
1100 W. 49th Street
Austin, Texas 78756-3199

TABLE OF CONTENTS

INFORMATION 2

I. INTRODUCTION 2

II. RENEWAL APPLICATION DEADLINE AND SUBMISSION 4
- A. Deadline 4
- B. Assembly and Submission 4

ORGANIZATION AND CONTENT 6

III. RENEWAL APPLICATION ORGANIZATION AND CONTENT 6

IV. BLANK FORMS AND INSTRUCTIONS 6
- FORM A: FACE PAGE – Renewal Application for EACPS as authorized under Early Access to Clinical and Preventive Services for Persons with HIV Disease, issued 03/22/02, ... 8
- Identifier # RFP-HIV-0031 8
- FORM A: FACE PAGE Instructions 9
- FORM B: RENEWAL APPLICATION CHECKLIST 11
- FORM C: PROGRAM CONTACT INFORMATION 12
- FORM D: ADMINISTRATIVE INFORMATION - Renewal Application 13
- FORM E: PERFORMANCE MEASURES 15
- FORM E: PERFORMANCE MEASURE Guidelines 16
- FORM F: WORK PLAN 17
- FORM F: WORK PLAN Guidelines 18
- FORM G: BUDGET SUMMARY 19
- FORM G: BUDGET SUMMARY Instructions 20
- FORM G: BUDGET SUMMARY Sample 21
- DETAILED BUDGET CATEGORY FORMS General Information 22
- FORM G-1: PERSONNEL Budget Category Detail Form 24
- FORM G-1: PERSONNEL Budget Category Detail Form Sample 25
- FORM G-2: TRAVEL Budget Category Detail Form 26
- FORM G-2: TRAVEL Budget Category Detail Form Sample 27
- FORM G-3: EQUIPMENT Budget Category Detail Form 28
- FORM G-3: EQUIPMENT Budget Category Detail Form Sample 29
- FORM G-4: SUPPLIES Budget Category Detail Form 30
- FORM G-4: SUPPLIES Budget Category Detail Form Sample 31
- FORM G-5: CONTRACTUAL Budget Category Detail Form 32
- FORM G-5: CONTRACTUAL Budget Category Detail Form Sample 33
- FORM G-6: OTHER Budget Category Detail Form 34
- FORM G-6: OTHER Budget Category Detail Form Sample 35
- FORM G-7: INDIRECT COST Budget Category Detail Form 36
- FORM G-7: INDIRECT COST Budget Category Detail Form Sample 37
- FORM H: NONPROFIT BOARD OF DIRECTORS AND EXECUTIVE DIRECTOR ASSURANCES FORM 38
- FORM I: HIV CONTRACTOR ASSURANCES 39
- FORM J: ASSURANCE REGARDING PHARMACY NOTIFICATION 41
- FORM K: ASSURANCE REGARDING STANDARDS FOR CLINICAL AND CASE MANAGEMENT SERVICES 42

INFORMATION

I. INTRODUCTION

Current TDH contractors receiving funds from the Early Access to Clinical and Preventive Services for Persons with HIV Disease (EACPS)/RFP-HIV-0031 are requested to submit a renewal application for the second budget period within the four-year project period. Renewal contracts will begin on or about 09/01/03 and will be for a 12-month budget period.

The Texas Department of Health (TDH) reserves the right to negotiate any terms and conditions including budget amounts and allocations. Any contract renewal is contingent upon the continued availability of funding to TDH.

Program funds may be used for ambulatory medical and preventive clinical services, critical social services, resources for obtaining HIV medications, as appropriate, and for the costs of providing outreach to persons with diagnosed HIV disease who are not currently included in activities undertaken by the agency. Program activities performed under the contract must include primary and/or HIV-related ambulatory medical care, and/or clinical case management services, and/or psychosocial case management services. At least 50 percent of the proposed budget must directly support one or more of these services. All contractors must also directly provide or provide referral to screening, treatment as needed, and follow-up for sexually transmitted diseases.

EACPS services that are eligible for funding include, but are not limited to:

1. HIV-related ambulatory medical care and primary ambulatory medical care
2. Specialty medical care related to HIV disease or AIDS
3. Psychiatric medical management of mental illness
4. Nursing care
5. Dental care, including preventive dental care
6. Screening and diagnostic tests and procedures for conditions related to HIV disease
7. Laboratory services, including periodic viral load, phenotype and/or genotype testing when conducted according to nationally recognized clinical practice guidelines
8. Radiology services, including ambulatory x-ray, computerized tomography, magnetic resonance imaging and other procedures to diagnose conditions related to HIV disease
9. Gynecological services for women (including Pap smear, colposcopy, mammography)
10. Screening and treatment of sexually transmitted diseases, including syphilis, gonorrhea and chlamydia in people with existing HIV infection
11. Emergency care (after hours, weekends and holidays only, unless the client has been assessed by a physician or R.N. and provision of care in an emergency setting is judged to be clinically necessary)

12. Clinical case management services, including linkage to the Texas HIV Medication Program and other resources for medications related to HIV disease
13. Psychosocial case management services
14. Psychological counseling and mental health services provided by a licensed therapist (e.g., Ph.D., L.M.S.W., L.P.C., etc.)
15. Nutrition counseling and education by a licensed dietician/registered dietician
16. Nutritional support (food pantry, nutritional supplements, etc)
17. Prescription medications to treat conditions related to HIV disease, as defined by the clinician (physician, advanced practice nurse or physician assistant)[1]
18. Over-the-counter medications
19. Drug therapy to prevent opportunistic infections (See [1].)
20. Comprehensive immunization services, including hepatitis-B virus vaccine, influenza vaccine, pneumovax, tetanus/diphtheria vaccine, etc.
21. Prenatal care for pregnant women with HIV disease that is not funded by other resources (e.g., Medicaid)
22. Transportation for services related to HIV disease
23. Referrals for substance abuse treatment, HIV-related clinical trials, medical specialty and tertiary care, and
24. Other proven disease prevention and health promotional activities and services that creat improved health care outcomes.

The TDH requires collaboration between EACPS grantees and other HIV-related programs within the HIV Services Delivery Area (HSDA), including pediatric service demonstration projects; Title I, II, III, IV and V recipients; community, migrant, and homeless health centers; local and regional public health officials; community groups; and, individuals with expertise in the delivery of HIV/AIDS services and knowledge of the needs of the target population. Formal linkages with hospital discharge planners, and Prevention Counseling and Partner Elicitation (PCPE) sites are encouraged. Grantees are required to collaborate with local tuberculosis prevention/control programs to obtain diagnosis and treatment for HIV clients, and with any HIV Early Access projects funded by the Texas Commission on Alcohol and Drug Abuse

Grantees are further required to provide services that are equitably available and accessible to all HIV infected individuals needing services/care in the service area. Grantees must employ outreach methods to reach and provide services to eligible clients who may not otherwise be able to access the services. Grantees

1 All potentially eligible clients must be referred to the Texas HIV Medication Program (THMP) for medications related to HIV disease that are included on the THMP formulary. Only after a client has been deemed ineligible for the THMP or denied purchase of a prescribed medication(s) covered by the THMP may EACPS funds be used to purchase this medication(s). Contracted agencies may not supercede the decision of the treating clinician in determining whether or not a prescribed medication is being used to treat a "condition related to HIV disease" when determining whether or not to purchase the medication. Contractors may work in cooperation with clinicians to determine whether or not the agency has sufficient funds to purchase prescribed medications and to assist the client to locate other resources to obtain the medications when sufficient funds are not available.

must provide for services so that hours of operation, availability of public transportation, and location do not create barriers to the access of services by those who need them. Grantees must agree to provide services to any qualifying individual who resides in the service area, regardless of their ability to pay.

II. RENEWAL APPLICATION DEADLINE AND SUBMISSION

A. Deadline

The renewal application shall be received on or before the following date and time: **5:00 P.M. C.S.T. on 04/28/03.**

B. Assembly and Submission

1. Assembly

To facilitate review and processing, each renewal application should meet the following stylistic requirements:

- All pages clearly and consecutively numbered
- original and two copies unbound
- Typed (computer or typewriter)
- Single-spaced
- 12-point font on 8 ½" x 11" paper with 1" margins
- Blank forms provided in **SECTION VI. BLANK FORMS AND INSTRUCTIONS** shall be used (electronic reproduction of the forms is acceptable)
- Signed in ink by an authorized official (copies need not bear an original signature).

2. Submission

The originally signed renewal application and two copies shall be submitted to:

ASC ADCP – Contracting Section
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199
Attention: Sharon Golden

One copy of the renewal application shall be submitted to the appropriate TDH Regional HIV Coordinator.

The physical address for overnight and personal deliveries is:

ASC ADCP – Contracting Section
Texas Department of Health
1100 West 49th Street, Room G-301

Austin, Texas 78756-3199
Attention: Sharon Golden

TDH will not accept renewal applications by facsimile or e-mail.

Renewal applications may be mailed or hand-delivered to the TDH program address above on or before the deadline.

If a renewal application is hand-delivered to the TDH program address above, applicants should request a receipt at the time of delivery to verify that the application was received by the appropriate program on or before the due date and time.

If a renewal application is mailed, it is considered as meeting the deadline if it is received on or before the due date and time.

III. RENEWAL APPLICATION ORGANIZATION AND CONTENT

The renewal application should be organized in the following order:

A. Face Page - Renewal Application as authorized under Early Access to Clinical and Preventive Services for Persons with HIV Disease, issued [03/22/02, Identifier # RFP-HIV-0031

B. Renewal Application Checklist

C. Contact Person Information

D. Administrative Information

E. Performance Measures (if changed since last submission)

F. Work Plan (if changed since last submission)

G. Budget

H. Nonprofit Board of Directors and Executive Director Assurances Form

I. HIV Contractor Assurances

J. Assurance Regarding Pharmacy Notification

K. Assurance Regarding Standards for Clinical and Case Management Services

IV. BLANK FORMS AND INSTRUCTIONS

Only the forms used in this packet should be used to submit the renewal application. Additional copies of forms and electronic versions of the forms may be obtained at http://www.tdh.state.tx.us/hivstd/grants/default.html.

To use the check box on electronic forms, place the pointer over the box and double click the left mouse button. In the Check Box Form Field Options, change the Default Value to Checked by clicking the circle in front of it.

Unlocked Forms

To have the computer do the addition:

1. Completely fill out the column or row you are going to sum. If you are summing all of the totals, update the sum all of the columns and all of the rows before updating the sum of the totals.
2. Word will **not** update the totals automatically. Select the form field for the sum in one of the following ways:
   - Use the tab key to move from field to field or place the cursor immediately in front of the "0" or previous total with gray shading.
   - Drag the cursor over the "0" or previous total with gray shading so that only number is selected. Note: If the entire table cell is selected (black), the formula will not work and you risk deleting the form field.

   Tip: The first time you use the forms, the totals are all "0" with gray shading. Before updating a total, Zoom in until you can easily see the "0" and the gray shading.
3. Press the F9 key (usually at the top of the keyboard).
4. Check the results. If it looks wrong, check the numbers you put in the row or column.

Caution: Never delete the form field for the total (the "0," or previous total, with gray shading. The formulas will not work after the form field for the total is deleted. Selecting the field and typing over it will delete the field. The Backspace key will delete the field. The Delete key will delete the field.

Tip: You must update the totals for the columns and rows each time you change a number in that column or row.

Locked Forms

Fill in the form by entering information in the form fields. You can use the TAB and SHIFT + TAB or the arrow keys to move between fields.

To have the computer do the addition:

1. Use the tab key to move from field to field. Completely fill out the column or row you are going to sum.
2. Word will **not** update the totals automatically. On the Tools menu, click Options, and then click the Print tab.
3. Under Printing options, click the Update fields check box. Print the document or the changed page and the new sum will be calculated.
4. Check the results. If it looks wrong, check the numbers you put in the row or column.

Tip: You must update the totals for the columns and rows each time you change a number in that column or row.

Texas Department of Health
FORM A: FACE PAGE – Renewal Application for EACPS as authorized under Early Access to Clinical and Preventive Services for Persons with HIV Disease, issued 03/22/02, Identifier # RFP-HIV-0031

This form requests basic information about the applicant and project, including the signature of the authorized representative. The face page is the cover page of the renewal application and shall be completed in its entirety.

APPLICANT INFORMATION

1) LEGAL NAME:

2) MAILING Address Information (include mailing address, street, city, county, state and zip code): **Check if address change** ☐

3) PAYEE Mailing Address (if different from above): **Check if address change** ☐

4) Federal Tax ID No. (9 digit) or **State of Texas Comptroller Vendor ID No.** (14 digit):

5) TYPE OF ENTITY (check all that apply):

- ☐ City
- ☐ County
- ☐ Other Political Subdivision
- ☐ State Agency
- ☐ Indian Tribe
- ☐ Nonprofit Organization*
- ☐ For Profit Organization*
- ☐ HUB Certified
- ☐ Community-Based Organization
- ☐ Minority Organization
- ☐ Individual
- ☐ State Controlled Institution of Higher Learning
- ☐ Hospital
- ☐ Private
- ☐ Other (specify): _____

**If incorporated, provide 10-digit charter number assigned by Secretary of State:*

6) Currently operating under a HUB Subcontracting plan on file at TDH? Yes ☐ No ☐

7) PROPOSED BUDGET PERIOD: Start Date: End Date:

8) COUNTIES SERVED BY PROJECT:

9) AMOUNT OF FUNDING REQUESTED:

10) PROJECTED EXPENDITURES

Does applicant's projected state or federal expenditures exceed $300,000 for applicant's current fiscal year (excluding amount requested in line 8 above)? **

Yes ☐ No ☐

***Projected expenditures should include funding for all activities including "pass through" federal funds from all state agencies and non project-related TDH funds.*

11) PROJECT CONTACT PERSON

Name:
Phone:
Fax:
E-mail:

12) FINANCIAL OFFICER

Name:
Phone:
Fax:
E-mail:

I, the undersigned, am the authorized representative of the applicant filing this contract renewal application. The facts contained herein are true, and the applicant is in compliance with the assurances and certifications contained in the competitive RFP identified above, which is part of the original contract and any prior renewals and amendments. I understand that this contract renewal depends on the truthfulness of this document and on the applicant's continued compliance with the original contract and all its components and amendments.

13) AUTHORIZED REPRESENTATIVE

Name:
Phone:
Fax:
E-mail:

14) SIGNATURE OF AUTHORIZED REPRESENTATIVE

15) DATE

FORM A: FACE PAGE Instructions

This form provides basic information about the applicant and the proposed project with the Texas Department of Health (TDH), including the signature of the authorized representative. It is the cover page of the renewal application and required to be completed. Signature affirms that the facts contained in the applicant's response are truthful and that the applicant is in compliance with the assurances and certifications contained in the identified Competitive Request for Proposal and the original TDH contract, any renewal(s) or amendment(s). Applicant acknowledges that continued compliance is a condition for the renewal of a contract. Please follow the instructions below to complete the face page form and return with the applicant's response.

1) **LEGAL NAME** - Enter the legal name of the applicant.

2) **MAILING ADDRESS INFORMATION** - Enter the applicant's complete street and mailing address, city, county, state, and zip code.

3) **PAYEE MAILING ADDRESS** - Enter the PAYEE's name and mailing address if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.

4) **FEDERAL TAX ID/STATE OF TEXAS COMPTROLLER VENDOR ID** - Enter the Federal Tax Identification Number (9-digit) or the Vendor Identification Number assigned by the Texas State Comptroller (14-digit).

5) **TYPE OF ENTITY** - The type of entity is defined by the Secretary of State and/or the Texas State Comptroller. Check all appropriate boxes that apply.

   HUB is defined as a corporation, sole proprietorship, or joint venture formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons who have been historically underutilized (economically disadvantaged) because of their identification as members of certain groups: Black American, Hispanic American, Asian Pacific American, Native American, and Women. The HUB must be certified by the General Services Commission or another entity.

   MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.

   If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.

6) **CURRENTLY OPERATING UNDER A HUB SUBCONTRACTING PLAN ON FILE AT TDH? YES OR NO** - Check the appropriate box to indicate whether or not the applicant is operating under a HUB Subcontracting Plan filed with TDH under the original competitive RFP. If yes, the applicant must continue to comply with reporting requirements if a renewal contract is executed. Any changes to the budget which affect the HUB Subcontracting Plan must be communicated with the TDH HUB Coordinator at 1-800-243-7487 or by e-mail at al.beavers@tdh.state.tx.us. If no is checked, no further action is required.

7) **PROPOSED BUDGET PERIOD** - Enter budget period as identified in this renewal application.

8) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project.

9) **AMOUNT OF FUNDING REQUESTED -** Enter the amount of funding requested from TDH for proposed project activities. This amount must match column (1) row K from FORM I: BUDGET SUMMARY.

10) **PROJECTED EXPENDITURES** - If applicant's projected state or federal expenditures exceed $300,000 for applicant's current fiscal year, applicant shall arrange for a financial and compliance audit (Single Audit).

11) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and e-mail address of the person responsible for the proposed project.

12) **FINANCIAL OFFICER** - Enter the name, phone, fax, and e-mail address of the person responsible for the financial aspects of the proposed project.

13) **AUTHORIZED REPRESENTATIVE** - Enter the name, phone, fax, and e-mail address of the person authorized to represent the applicant.

14) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the applicant signs in this blank.

15) **DATE** - Enter the date the person authorized to represent the applicant signed this form.

FORM B: RENEWAL APPLICATION CHECKLIST

Legal Name of Applicant: _____

This form is provided to ensure that the renewal application is complete and properly signed.

FORM	DESCRIPTION	Included	Not Applicable
A	Face Page – Renewal Application completed, and proper signatures and date included	☐	
B	Renewal Application Checklist completed and included	☐	
C	Contact Person Information completed and included	☐	
D	Administrative Information for Renewal Application completed and included (with supplemental documentation attached if required)	☐	
E	Performance Measures included	☐	☐
F	Work Plan included	☐	☐
G	Budget Summary Form completed and included	☐	
G-1–G-7	Budget Category Detail Forms completed and included	☐	
H	Nonprofit Board of Directors and Executive Director Assurances form signed and included If the signed original of this form has been provided to the Texas Department of Health during the calendar year and the officers signing the document have not changed, a copy of the signed form will be accepted.	☐	☐
I	HIV Contractor Assurances	☐	
J	Assurance Regarding Pharmacy Notification	☐	
K	Assurance Regarding Standards for Clinical and Case Management Services	☐	

[Program may customize the Applicant Checklist and mark items as "not applicable" as appropriate. NOTE: If using a unit cost reimbursement methodology, omit the Budget Summary Form and Budget Category Detail Forms from checklist.]

FORM C: PROGRAM CONTACT INFORMATION

Legal Name of Applicant: ______________________________

This form provides information about the appropriate program contacts in the applicant's organization in addition to those on FORM A: FACE PAGE. If any of the following information changes during the term of the contract, please notify the ***[program name]****.*

[program name] Contact: ____________	**Mailing Address (incl. street, city, county, state, & zip):**
Title: ____________	____________
Phone: ____________	____________
Fax: ____________	____________
E-mail: ____________	____________
[program name] Contact: ____________	**Mailing Address (incl. street, city, county, state, & zip):**
Title: ____________	____________
Phone: ____________	____________
Fax: ____________	____________
E-mail: ____________	____________
[program name] Contact: ____________	**Mailing Address (incl. street, city, county, state, & zip):**
Title: ____________	____________
Phone: ____________	____________
Fax: ____________	____________
E-mail: ____________	____________
[program name] Contact: ____________	**Mailing Address (incl. street, city, county, state, & zip):**
Title: ____________	____________
Phone: ____________	____________
Fax: ____________	____________
E-mail: ____________	____________
[program name] Contact: ____________	**Mailing Address (incl. street, city, county, state, & zip):**
Title: ____________	____________
Phone: ____________	____________
Fax: ____________	____________
E-mail: ____________	____________

[Program may customize the Contact Person Information form to obtain program-specific contacts OR omit this form if none required. Information for Financial Officer and Project Contact Person are already included in the FACE PAGE.]

FORM D: ADMINISTRATIVE INFORMATION - Renewal Application

This form provides information regarding identification and contract history on the applicant, executive management, project management, governing board members, and/or principal officers. Respond to each request for information ***or provide the required supplemental document behind this form.*** *If responses require multiple pages, identify the supporting pages/documentation with the applicable request.*

Legal Name of Applicant: _____

Identifying Information

If there are no changes to any of the items below, check here and skip the next question in this section. ☐

1. The applicant shall attach the following information:

If a Governmental Entity

- Names (last, first, middle) and addresses for the officials who are authorized to enter into a contract on behalf of the applicant.

If a Nonprofit or For profit Corporation

- Full names (last, first, middle), addresses, telephone numbers, titles and occupation of members of the Board of Directors or any other principal officers. Indicate what offices are held by members (e.g. chairperson, president, vice-president, treasurer, etc.).
- Full names (last, first, middle), and addresses for each partner, officer, and director as well as the full names and addresses for each person who owns five percent (5%) or more of the stock if applicant is a for profit corporation.

Conflict of Interest and Contract History

If there are no changes to any of the items below, check here and skip the questions in this section. ☐

The applicant shall disclose any existing or potential conflict of interest relative to the performance of the requirements of this renewal application. Examples of potential conflicts may include an existing business or personal relationship between the applicant, its principal, or any affiliate or subcontractor, with TDH, the participating agencies, or any other entity or person involved in any way in any project that is the subject of this renewal application. Similarly, any personal or business relationship between the applicant, the principals, or any affiliate or subcontractor, with any employee of TDH, a participating agency, or their respective suppliers, must be disclosed. Any such relationship that might be perceived or represented as a conflict shall be disclosed. Failure to disclose any such relationship may be cause for contract termination. If, following a review of this information, it is determined by TDH that a conflict of interest exists, the applicant may be disqualified from further consideration for the renewal of a contract.

1. Does anyone in the applicant organization have an existing or potential conflict of interest relative to the performance of the requirements of this renewal application?

☐ **YES** ☐ **NO**

If YES, detail any such relationship(s) that might be perceived or represented as a conflict. (Attach no more than one additional page.)

2. Has any member of applicant's executive management, project management, governing board or principal officers been employed by the State of Texas 24 months prior to the renewal application due date?

☐ **YES** ☐ **NO**

If YES, indicate his/her name, social security number, job title, agency employed by, separation date, and reason for separation.

3. Is applicant or any member of applicant's executive management, project management, board members or principal officers:

- delinquent on any state, federal or other debt;
- affiliated with an organization which is delinquent on any state, federal or other debt; or
- in default on an agreed repayment schedule with any funding organization?

☐ **YES** ☐ **NO**

If YES, please explain. (Attach no more than one additional page.)

FORM E: PERFORMANCE MEASURES

Complete Form E: Performance Measures only if changes are proposed to previously negotiated performance measures.

In the event a contract is renewed, applicant agrees that performance measures(s) will be used to assess, in part, the applicant's effectiveness in providing the services described. Address all of the requirements (see PERFORMANCE MEASURES Guidelines) associated with the services proposed in this renewal application. ***A maximum of two additional pages may be attached if needed.***

FORM E: PERFORMANCE MEASURE Guidelines

Applicant shall include the performance measures in the renewal application along with the proposed target levels of performance for each measure. The proposed target levels of performance and reporting frequency will be negotiated and agreed upon by applicant and TDH if applicant is selected to negotiate a contract.

All applicants must include the following performance measures:

- PERFORMING AGENCY shall provide an estimate ___ clients with direct provision of or referral to screening, treatment as needed, and follow-up for sexually transmitted disease who live or receive services in the following county(ies)/area:

- PERFORMING AGENCY shall collect and maintain relevant data documenting the progess toward the goals and objectives of the project, as well as any other data requested by RECEIVING AGENCY Program. All data shall be submitted in a format as provided by RECEIVING AGENCY Program due within the required time frame as specified by RECEIVING AGENCY program.

- PERFORMING AGENCY shall provide a program report of progress toward meeting the program objectives, quarterly as well as year-to-date. Such reports shall be submitted in a format as provided by RECEIVING AGENCY Program due on or before the twentieth (20^{th}) calendar day of December 2003, and March, June and September 2004.

Additionally, applicants must include one or more of the following performance measures:

- PERFORMING AGENCY shall provide an estimate ___ clients with ambulatory medical care services after diagnosis of HIV infection who live or receive services in the following county(ies)/area:

- PERFORMING AGENCY shall provide an estimated ___ clients with clinical case management services after diagnosis of HIV infection who live or receive services in the following county(ies)/area:

- PERFORMING AGENCY shall provide an estimated ___ clients with psychosocial case management services after diagnosis of HIV infection who live or receive services in the following county(ies)/area:

FORM F: WORK PLAN

Complete Form F: Work Plan only if changes are proposed to previously negotiated work plan.

Applicants shall describe its plan for service delivery to the population in the proposed service area(s) and include timelines for accomplishments. Address the required elements (see WORK PLAN Guidelines) associated with the services proposed in this renewal application. ***A maximum of five additional pages may be attached if needed.***

FORM F: WORK PLAN Guidelines

Applicant shall describe its plan for service delivery to the population in the proposed service area(s) and include time lines for accomplishments. The work plan shall address any changes to the needs and the problems identified in the community assessment for improving health status. The plan shall:

a) Describe overall how the requested budget will be used to link people with HIV disease or AIDS to and provide necessary clinical, clinical case management and psychosocial supportive services;
b) How will the project provide these linkages and the provision of services as soon as possible in the course of the disease;
c) How will the project link people with HIV disease or AIDS to the THMP and other resources for obtaining access to appropriate medications to prevent perinatal transmission of HIV disease, to treat HIV disease and to prevent opportunistic illnesses;
d) How will the project perform other significant activities listed under the original RFP “General Purpose and Program Goals”;
e) How will the project assist clients to enter and benefit from the highest priority HIV services available in your area;
f) describe the goal(s) of your project;
g) describe the desired outcomes of the project;
h) describe who will benefit from the project and how they will benefit; and,
i) describe how HIV-infected individuals from the targeted population and their families have specifically be or will be involved in developing the project.

This section must be consistent with project performance measures.

FORM G: BUDGET SUMMARY

Legal Name of Applicant: _____

Cost Categories	TDH Funds Requested (1)	Direct Federal Funds (2)	Other State Agency Funds* (3)	Local Funding Sources (4)	Other Funds (5)	Total (6)
A. Personnel	$	$	$	$	$	$ 0
B. Fringe Benefits	$	$	$	$	$	$ 0
C. Travel	$	$	$	$	$	$ 0
D. Equipment	$	$	$	$	$	$ 0
E. Supplies	$	$	$	$	$	$ 0
F. Contractual	$	$	$	$	$	$ 0
G. Construction	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0
H. Other	$	$	$	$	$	$ 0
I. Total Direct Costs	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
J. Indirect Costs	$	$	$	$	$	$ 0
K. Total (Sum of I and J)	$ 0	$ 0	$ 0	$ 0	$ 0	$ 0
L. Program Income - Projected Earnings	$	$	$	$	$	$ 0

Indirect costs are based on (mark the statement that is accurate):

☐ The applicant's most recently approved indirect cost rate _____ % A copy is attached behind the OTHER Budget Category Detail Form (FORM I6).

☐ The applicant's most recently approved indirect cost rate _____ % which is on file with TDH's Grants Management Division.

☐ Uniform Grant Management Standards. Complete an INDIRECT COST Budget Category Detail Form (FORM I7).

***Letter(s) of good standing that validate the applicant's programmatic, administrative, and financial capability must be placed after this form if applicant receives any funding from other non-TDH state agencies. If the applicant is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include non-project related funding in column 3.**

FORM G: BUDGET SUMMARY Instructions

An accurate budget plan is essential to achieve the performance measures and work plan set out in the narrative portion of the renewal application. All applicants shall complete the budget summary form. Be sure to refer to the appropriate sections in the renewal application for program-specific allowable and unallowable costs.

This form shall reflect funding from all sources that support the project described in this attachment. See "Detailed Budget Category Forms, Instructions" for definitions of cost categories. For purposes of this form, the column headings have the following meanings:

Column 1: The amount of funds requested from the Texas Department of Health (TDH) for this project.
Column 2: Federal funds awarded directly to applicant.
Column 3: Funds awarded to applicant from other State of Texas governmental agencies.
Column 4: Funds awarded to applicant by local governmental agencies (city, county, local health department, etc.).
Column 5: Funds from other sources not previously addressed in columns 1-4 (third party reimbursements, private foundations, donations, fund-raising, etc.).
Column 6: The sum of columns 1-5.

PROGRAM INCOME

Program Income: Projected Earnings. Applicant shall estimate the amount of program income that is expected to be generated during the budget period.

DEFINITION: Program income is the income resulting from fees or charges made by a contractor in connection with activities supported in whole or in part by a federal/state contract. Program income earned as a result of an effort which is jointly funded by TDH and the contractor is to be shared by TDH and the contractor. A program income allocation plan is the means by which TDH's share is determined. The required formula for a plan is as follows:

$$\frac{\text{TDH's Share of Funding}}{\text{TDH's Share of Funding + Contractors Share of Funding}} \times \text{Total Program Income Collected} = \text{TDH's Share of Program Income}$$

Contractor shall disburse program income rebates, refunds, contract settlements, audit recoveries and interest earned on such funds before requesting cash payments including advance payments from TDH.

For more information about program income, refer to the Program Income Article in the General Provisions for TDH Grants Contracts and/or request a copy of TDH's Financial Administrative Procedures Manual from the Grants Management Division or on the Internet at www.tdh.state.tx.us/grants/form_doc.htm.

INSTRUCTIONS:
Projected Earnings. Applicant must enter on the BUDGET SUMMARY form the estimated amount of program income that is expected to be generated during the budget period.

Examples Of Program Income

- *Fees received for personal services performed in connection with and during the period of contract support;*
- *Tuition and fees when the course of instruction is developed, sponsored, and supported by the applicable contract from state or federal sources;*
- *Sale of services such as laboratory tests or computer time;*
- *Payments received from patients or third parties for medical or hospital service, such as Title XIX or Title XX reimbursements, insurance payments, or patient fees. These payments may be made under either a cost reimbursement or a fixed price agreement;*
- *Lease or rental of films or video tapes; and*
- *Rights or royalty payments resulting from patents or copyrights developed or acquired by the contractor.*

[If using a unit cost reimbursement methodology, omit the Budget Summary Form and Budget Category Detail Forms and insert the appropriate unit cost forms and instructions. If a Program requires applicants to establish the unit rate, include the following statement as a renewal application budget requirement on the form: "Applicant certifies that the unit rate requested is the price given to applicant's most favored customer."]

SAMPLE

FORM G: BUDGET SUMMARY Sample

Legal Name of Applicant: Apple County Health Department

Cost Categories	TDH Funds Requested (1)	Direct Federal Funds (2)	Other State Agency Funds* (3)	Local Funding Sources (4)	Other Funds (5)	Total (6)
A. Personnel	$ 27,900	$ 30,900	$ 5,000	$ 0	$ 0	$ 63,800
B. Fringe Benefits	$ 4,032	$ 5,030	$ 1,000	$ 0	$ 0	$ 10,062
C. Travel	$ 1,373	$ 2,070	$ 5,00	$ 0	$ 0	$ 3,448
D. Equipment	$ 2,060	$ 3,050	$ 2,050	$ 1,500	$ 0	$ 8,660
E. Supplies	$ 45,000	$ 46,000	$ 20,000	$ 5,500	$ 0	$ 116,500
F. Contractual	$ 41,208	$ 42,010	$ 15,000	$ 0	$ 0	$ 98,218
G. Construction	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0
H. Other	$ 23,000	$ 1,000	$ 500	$ 0	$ 0	$ 24,500
I. Total Direct Costs	$ 144,573	$ 130,060	$ 44,050	$ 7,000	$ 0	$ 325,683
J. Indirect Costs	$ 2,025	$ 900	$ 650	$ 0	$ 0	$ 3,575
K. Total (Sum of I and J)	$ 146,598	$ 130,960	$ 44,700	$ 7,000	$ 0	$ 329,258
L. Program Income --Projected Earnings	$ 13,200	$ 12,000	$ 4,200	$ 600	$ 0	$ 30,000

Indirect costs are based on (mark the statement that is accurate):

☐ The applicant's most recently approved indirect cost rate _____ % A copy is attached behind the OTHER Budget Category Detail Form (FORM I6).

☐ The applicant's most recently approved indirect cost rate _____ % which is on file with TDH's Grants Management Division.

☒ Uniform Grant Management Standards. Complete an INDIRECT COST Budget Category Detail Form (FORM I7).

***Letter(s) of good standing that validate the applicant's programmatic, administrative, and financial capability must be placed after this form if applicant receives any funding from other non-TDH state agencies. If the applicant is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include non-project related funding in column 3.**

DETAILED BUDGET CATEGORY FORMS
General Information

Requirements for Categorical Budgets
The renewal application shall include a detailed breakdown of budget cost categories and a narrative justification. Details of each cost category shall be expressed using the budget category detail forms (G-1 to G-7), which follow. Definitions of the cost categories and instructions and examples of how to itemize the contents of each cost category are included after the budget category detail forms. Computer generated facsimiles may be substituted for any of the forms; however, the exact wording and format must be maintained.

General Information
Additional information on basic accounting and financial management systems requirements is available in TDH's Financial Administrative Procedures Manual. Copies of the manual are available from the Grants Management Division or on the Internet at www.tdh.state.tx.us/grants/form_doc.htm.

Only those costs allowable under UGMS and any revisions thereto plus any applicable federal cost principles are eligible for reimbursement under this contract. Applicable cost principles, audit requirements, and administrative requirements are as follows:

Applicable Cost Principles	Audit Requirements	Administrative Requirements
OMB Circular A-87, State & Local Governments	OMB Circular A-133	UGMS
OMB Circular A-21, Educational Institutions	OMB Circular A-133	OMB Circular A-110
OMB Circular A-122, Non Profit Organizations	OMB Circular A-133 and UGMS	UGMS
48 CFR Part 31, For Profit Organization and other than a hospital and an organization named in OMB Circular A-122 as not subject to that circular	Program audit conducted by an independent certified public accountant must be in accordance with Governmental Auditing Standards.	

A. Allowable and Unallowable Costs
Below is a brief listing of allowable and unallowable costs as prescribed by federal cost principles or TDH policy. Applicable federal cost principles provide additional information and guidance on allowable and unallowable costs.

An **allowable cost**, in accordance with federal cost principles, meets the following criteria:
1. It is necessary and reasonable for proper and efficient administration of the funded program;
2. It can be allocated to the funded program and is not a general expense needed to carry out the contractor's general responsibilities;
3. It is authorized or is not prohibited under applicable laws or regulations;
4. It conforms to applicable limitations or exclusions;
5. It is consistent with applicable policies and procedures;
6. It is treated consistently through the renewal application of generally accepted accounting principles appropriate to the circumstances;
7. It is not allocated or included as a cost of any other program; and
8. It is the net sum of all applicable credits.

Unallowable costs, i.e., costs that may not be paid with TDH funds include, but are not limited to:

1. Advertising and public relations costs other than those specifically allowed by terms of the contract attachment or those incurred for the purpose of personnel recruitment, solicitation of bids and disposal of surplus materials;
2. Bad debts;
3. Construction is not allowed without the prior written approval of TDH;
4. Contingency reserve funds;
5. Contributions and donations;
6. Entertainment costs including amusement/social activities and their related costs (meals, beverages, lodgings, rentals, transportation, and gratuities) are not allowed unless the costs are directly related to the program's purpose and TDH has reviewed and issued prior written approval of the work plan components that relate to entertainment costs;
7. Fines, penalties, late payment fees, bank overdraft charges;
8. Fundraising;
9. Interest (unless specifically authorized by applicable cost principles or authorized by federal or state legislation);
10. Lobbying.

B. Direct Costs

Direct costs are those that can be specifically identified with a particular award, project, service, scope of work or other direct objective of an organization. These costs may be charged directly to the TDH contract attachment (if contract is renewed). These costs may also be charged to cost objectives used to accumulate all costs pending distribution to specific contracts and other purposes. Direct cost categories include: personnel, fringe benefits, travel, equipment, supplies, contractual, and other.

C. Indirect Costs

Indirect costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective. The amount of indirect costs that may be charged to any resulting TDH contract attachment is determined by negotiation and will be defined in the contract budget attachment.

D. Audit Requirements

If required by OMB Circular A-133 and/or UGMS, applicant or applicant's authorized contracting entity shall arrange for a financial and compliance audit (Single Audit). Applicant may include in the budget request an amount for TDH's proportionate share of costs. The audit must be conducted by an independent CPA and must be in accordance with applicable OMB Circulars, Government Auditing Standards, and UGMS. Audit services shall be procured in compliance with state procurement procedures, as well as the provisions of UGMS.

FORM G-1: PERSONNEL Budget Category Detail Form

Legal Name of Applicant: _____

Functional Title + Code E=Existing or P=Proposed	% Time	Certification/ License Required	Total Annual Salary	Salary Requested for Project	Vacant Y/N	Justification

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space. Attach an additional sheet of paper if more space is required.

Salary Total	$ 0
Fringe Benefit Rate %	%
FRINGE BENEFITS TOTAL	$

SAMPLE

FORM G-1: PERSONNEL Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Functional Title + Code E=Existing or P=Proposed	% Time	Certification/ License Required	Total Annual Salary	Salary Requested for Project	Vacant Y/N	Justification
Financial Officer (E)	5%		$42,000	$2,100	N	Provides financial accountability of program
Administrative/Personnel (P)	5%		$36,000	$1,800	Y	Provides personnel services and training
Outreach Counselor (E)	100%		$24,000	$24,000	N	Provides outreach/case management services

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space. Attach an additional sheet of paper if more space is required. FICA 7.65% Worker's Comp 2.05% Retirement Plan 1.63% Health Insurance 3.12%	Salary Total	$27,900
	Fringe Benefit Rate 14.45 % FRINGE BENEFITS TOTAL	$4,032

PERSONNEL

DEFINITION: Actual salaries and wages for all staff positions in the proposed project that will provide direct care and administrative services (including clerical) to the project.

INSTRUCTIONS: Enter the following information for each position on the PERSONNEL Budget Category Detail Form: functional title, whether the position is existing or proposed, % of time dedicated to the project, any certification or license an individual must possess to be qualified for the position, the total annual salary, the amount of TDH funds requested for this position's salary (% of time dedicated to the project multiplied by the annual salary), whether the position is vacant or filled, and the justification for the position. Justification may include a brief description of the position's primary responsibilities and an explanation for the % of time dedicated to the project, why the position classification is appropriate (including license/certification requirements), and an explanation of reasonableness of the annual salary.

FRINGE BENEFITS

DEFINITION: Fringe benefits paid by the applicant on behalf of its employees. This includes employer contributions for social security, retirement, health and accident insurance, and workers' compensation insurance. Fringe benefits requested should represent actual benefits paid for employees.

INSTRUCTIONS: Itemize the elements of fringe benefits and indicate the % rate on the PERSONNEL Budget Category Detail Form.

FORM G-2: TRAVEL Budget Category Detail Form

Legal Name of Applicant: _____

Local Travel Costs (mileage plus per diem)

Mileage Reimbursement Rate	Estimated Number of Miles	Estimated Mileage Cost (a)	Estimated Per Diem Costs (b)	Estimated Total Local Travel Costs (a) + (b)	Justification (include who or what position will be traveling, area or locations to cover, and why local travel is necessary to accomplish the project)
$		$	$	$ 0	

Conference/Workshop Costs

Name and/or Description of Conference/Workshop	Location (City)	No. of Applicant Employees Attending (for whom TDH funds are requested)	Estimated Travel Cost (# of miles x reimbursement rate; estimated airfare, etc.)		Estimated Per Diem Cost	Estimated Related Travel Costs (taxi, etc.)	Estimated Total Conference/ Workshop Cost	Justification
							0	
							0	
							0	
							0	
							0	
							0	
TOTAL for Conf/Workshop TRAVEL:				$ 0	$ 0	$ 0	$ 0	

Local TRAVEL Costs: $ 0	Conf/Workshop TRAVEL Costs: $ 0	Total TRAVEL Costs: $ 0

NOTE: All contracts with the Texas Department of Health require that a written travel policy be maintained by the contracting entity. Attach a copy of the travel policy as an appendix to the proposal. If a written travel policy is not in place, TDH's travel policy will be used.

SAMPLE

FORM G-2: TRAVEL Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Local Travel Costs (mileage plus per diem)

Mileage Reimbursement Rate	Estimated Number of Miles	Estimated Mileage Cost (a)	Estimated Per Diem Costs (b)	Estimated Total Local Travel Costs (a) + (b)	Justification (include who or what position will be traveling, area or locations to cover, and why local travel is necessary to accomplish the project)
$ .31	1,068	$ 331	$ 144	$ 475	Executive Director – Travel to all site locations in the nineteen county area for review, monitor, evaluate, and oversee clinic operations.

Conference/Workshop Costs

Name and/or Description of Conference/Workshop	Location (City)	No. of Applicant Employees Attending (for whom TDH funds	Estimated Travel Cost (# of miles x reimbursement rate; estimated airfare, etc.)		Estimated Per Diem Cost	Estimated Related Travel Costs (taxi, etc.)	Estimated Total Conference/ Workshop Cost	Justification
Family Planning Advisory Committee Meetings (4)	Austin	1	1,735 miles x $0.31/mile =	$538	$360	$0	$898	Clinic Services Director to attend Family Planning Committee meetings (4)
TOTAL for Conf/Workshop TRAVEL:				$538	$360	$0	$898	

Local TRAVEL Costs:	$475	Conf/Workshop TRAVEL Costs:	$898	Total TRAVEL Costs:	$1,373

NOTE: All contracts with the Texas Department of Health require that a written travel policy be maintained by the contracting entity. Attach a copy of the travel policy as an appendix to the proposal. If a written travel policy is not in place, TDH's travel policy will be used.

TRAVEL

DEFINITION: The costs of transportation, lodging, meals and related expenses incurred by the applicant's staff while traveling to perform duties required by the proposed project are classified as travel. This includes personal auto mileage for travel by employees. Costs related to client transportation, registration fees, and travel associated with contractual staff should be classified as "Other", not "Travel."

INSTRUCTIONS: The TRAVEL Budget Category Detail Form requires information on local travel costs (travel and per diem) and information on conferences/workshops for which TDH funding is being requested. For local travel, enter the reimbursement rate for automobile mileage and the estimated number of miles to be traveled for the budget period. To calculate the total estimated local travel costs, multiply the local reimbursement rate per mile by the total estimated number of automobile miles. Enter the estimated per diem costs which may be associated with local travel and show the basis for cost (15 partial days x $7 per partial day = $105). The justification should include who or what position classification(s) will be traveling and why local travel is necessary to accomplish the project. For conferences/workshops, the following must be included for all attending for whom TDH funds are being requested: the name and/or description of the conference/workshop, the location (city), the number of persons attending, estimated travel, per diem, other related travel costs (excluding registration fees) and total costs for all attending. The justification should include how attendance at the conference/workshop will directly benefit the project and why it is necessary to accomplish the project.

FORM G-3: EQUIPMENT Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached sample for equipment definition and detailed instructions to complete this form.

DESCRIPTION OF ITEM (≥ $1,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for EQUIPMENT:		$ 0.00	

SAMPLE

FORM G-3: EQUIPMENT Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order.

DESCRIPTION OF ITEM (≥ $1,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
Laptop Computer Dell Inspiron 8000, Intel Pentium III Processor at 850 MHZ, .32 KB Internal Cache (L1), 100 MHZ (Pentium III) external BUS, Frequency and 66 MHZ (Celeron) external BUS frequency Intel 815e AGP, Set Chipset with 4X AFP memory	$2,060 / 1	$2,060	Administrative processing and billing for Community Power Point presentation on the value of Family Planning
TOTAL Amount Requested for EQUIPMENT:		$ 2,060	

EQUIPMENT

DEFINITION: Equipment is defined by TDH as non-expendable personal property with a unit cost of more than $1,000.00 and a useful life of more than one year, with the following exceptions: fax machines, stereo systems, cameras, video recorders/players, microcomputers, printers, software, medical and laboratory equipment. Medical and laboratory equipment in this category is defined as microscopes, oscilloscopes, centrifuges, balances, and incubators. Medical and laboratory equipment not included in these five categories are not considered a capital asset unless the unit value is over $1,000.00. The exception items listed will still be inventoried if their unit cost plus any items used with or attached to the unit is $500.00 or greater. For items with component parts (i.e., computers), the aggregate cost must be considered when applying the $500/$1,000 threshold.

INSTRUCTIONS: Enter the following information on the EQUIPMENT Budget Category Detail Form for each type of equipment item: description of each item, the cost per unit, the number of units to be purchased, the total amount for the line item (multiply the cost per unit by the number of units), state the purpose for the item(s) and why the equipment is necessary and how the applicant determined or will determine that the cost is reasonable. Attach a complete specification or a copy of the purchase order.

EXAMPLES OF EQUIPMENT DESCRIPTIONS

Remember: Equipment is priced **per unit** including freight. If you intend to purchase 10 modems @ $95 each, this would be considered a supply item not an equipment item.

INCORRECT EXAMPLES

Computer-850 Mhz Pentium
1 @ $2,150
(insufficient description/specification)
1 @ $250 Laser Jet Printer
(This item would be moved to supplies as it is less than $500.00).

CORRECT EXAMPLES

Laptop Computer Dell Inspiron 8000, Intel Pentium III Processor at 850 MHz, .32 KB Internal Cache (L1), 100 MHZ (Pentium III) external BUS, Frequency and 66 MHZ (Celeron) external BUS frequency Intel 815e AGP, Set Chipset with 4X AFP memory.
1 @ $2,150
24" Zenith Portable TV/VCR Combination;
Model #Z12345
1 @ $750

FORM G-4: SUPPLIES Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the supply items listed below. Costs may be categorized by each general type (e.g., office, computer, medical, educational, janitorial, etc.). See attached sample for definition of supplies and detailed instructions to complete this form.

DESCRIPTION OF ITEM (≤ $1,000 excluding equipment exceptions)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for SUPPLIES:		$ 0.00	

SAMPLE

FORM G-4: SUPPLIES Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Itemize, describe and justify the supply items listed below. Costs may be categorized by each general type (e.g., office, computer, medical, educational, janitorial, etc.).

DESCRIPTION OF ITEM (≤ $1,000 excluding equipment exceptions)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
Office supplies	$750 / month	$9,000	Supports Family Planning clinic services
Pharmaceuticals	$3,000 / month	$36,000	Medications to serve patients
TOTAL Amount Requested for SUPPLIES:		$ 45,000	

SUPPLIES

DEFINITION: Costs for materials and supplies necessary to carry out the program. This includes medical supplies, drugs, janitorial supplies, office supplies, patient educational supplies, software less than $500, plus any equipment or furniture with a purchase price including freight not to exceed $1,000 per item, except those listed in the "equipment" category.

INSTRUCTIONS: Enter the following information in the SUPPLIES Budget Category Detail Form for each general category or type of supplies: description of the items, the cost per unit, the number of units to be purchased, the total amount for the line item (multiply the cost per unit by the number of units), and state the purpose for the item(s), why the supplies are necessary and how the applicant determined or will determine that the cost is reasonable.

FORM G-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Applicant: _____

List contracts for services related to the scope of work that are to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request, whichever is greater, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	METHOD OF REIMBURSEMENT (Unit Cost or Cost Reimbursement)	# of Hours or Units of Service	UNIT COST RATE (If Applicable)	CONTRACTOR TOTAL	JUSTIFICATION

TOTAL Amount Requested for CONTRACTUAL: $ 0

SAMPLE

FORM G-5: CONTRACTUAL Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

List contracts for services related to the scope of work that are to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request, whichever is greater, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	METHOD OF REIMBURSEMENT Reimbursement)	# of Hours or Units of Service	UNIT COST RATE (If Applicable)	CONTRACTOR TOTAL	JUSTIFICATION
Dr. Bob Health, D.O.	Oversees medical services	Unit Cost	month	$300	$3,600	Medical Director required by TDH
Dr. Peter Paul, D.O.	Provides health history & physicals	Unit Cost	130 hours/ month	$3,034	$36,408	Contract physician at clinics performing medical exams
Dr. Billy Bob, D.O.	Provide professional guidance	Cost Reimburse	N/A	N/A	$1,200	Medical Consultant
				TOTAL Amount Requested for CONTRACTUAL:	$ 41,208	

CONTRACTUAL

DEFINITION: Activities identified in the scope of work that are delegated by the applicant to a third party; the cost of providing these activities is recorded in this category. Travel costs incurred by a third party while performing these activities should be included in this category. Contracts for administrative services are not included in this category; they are properly classified in the Other category.
If the applicant enters into grant contracts with subrecipients or procurement contracts with vendors, the documents will be in writing and will comply with the requirements specified in the Contracts with Subrecipients and Contracts for Procurement articles in the General Provisions for Texas Department of Health Grant Contracts available online at *www.tdh.state.tx.us/grants/form_doc.htm* or by calling Grants Management Division at 512-458-7470.

If an applicant plans to enter into a contract which delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request whichever is greater, the applicant must submit justification to TDH and receive prior written approval from TDH before entering into the contract.

INSTRUCTIONS: The CONTRACTUAL Budget Category Detail Form requires names of the individuals or organizations performing the services, a description of the services being contracted, the number of hours or units of service to be purchased, the method of reimbursement (cost reimbursement or unit cost), unit cost if applicable and total amount of each subcontract. Justification should include why applicant intends to contract for the service, why the service is necessary to perform the scope of work and how the applicant will ensure that the cost of the service is reasonable.

Justification for contracts that delegate a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request whichever is greater, must be attached behind the CONTRACTUAL Budget Category Detail Form.

FORM G-6: OTHER Budget Category Detail Form

Legal Name of Applicant: _____

DESCRIPTION	(# of units x unit cost if applicable)	COST	PURPOSE & JUSTIFICATION

TOTAL Amount Requested for OTHER:	$	0

SAMPLE

FORM G-6: OTHER Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

DESCRIPTION	# of units x unit cost if applicable	COST	PURPOSE & JUSTIFICATION
Telephone (23 lines)	12 months x $833.34 =	$10,000	Telephone service
Printing	12 months x $666.67 =	$8,000	Documents, forms, letters, and literature
Single Audit	1 x $5,000 =	$5,000	Single Audit (TDH requirement)
TOTAL Amount Requested for OTHER:	$	23,000	

OTHER

DEFINITION: All other allowable direct costs not listed in any of the above categories are to be included in this category. Some of the major costs that should be budgeted in this category are:

* contracts for administrative services;
* space and equipment rental;
* utilities and telephone expenses;
* data processing services;
* printing and reproduction expenses;
* postage and shipping;
* contract clerical or other personnel services;
* janitorial services;
* exterminating services;
* security services;
* insurance and bonds;
* equipment repairs or service maintenance agreements;
* books, periodicals, pamphlets, and memberships;
* advertising;
* registration fees;
* patient transportation;
* training costs, speakers fees and stipends.

INSTRUCTIONS: The OTHER Budget Category Detail Form requires a general description of the service, and the cost. The justification should include an explanation of the purpose of the service and how it is necessary for the completion of the activity. The justification should also include a statement of when services will be utilized if other than the full renewal application budget period.

FORM G-7: INDIRECT COST Budget Category Detail Form

Legal Name of Applicant: _____

Complete this form if requesting funds for indirect costs based on Uniform Grants Management Standards. The justification should include an explanation of the purpose of the service and how it is necessary for the completion of the activity.

DESCRIPTION	PURPOSE & JUSTIFICATION
Total Amount Requested for INDIRECT COST:	$

SAMPLE

FORM G-7: INDIRECT COST Budget Category Detail Form Sample

Legal Name of Applicant: Apple County Health Department

Complete this form if requesting funds for indirect costs based on Uniform Grants Management Standards. The justification should include an explanation of the purpose of the service and how it is necessary for the completion of the activity.

DESCRIPTION	PURPOSE & JUSTIFICATION
General administration and maintenance	$2,025
Total Amount Requested for INDIRECT COST:	$2,025

INDIRECT COSTS

DEFINITION: Those costs related to the project that are not included in direct costs. Indirect costs are those costs incurred for a common or joint purpose benefiting more than one cost objective and not readily identified with a particular cost center and which may be paid if allowable under the funding source, e.g., depreciation and use allowances, interest, operation and maintenance expenses (janitorial and utility services, repairs and normal alterations of buildings, furniture, equipment, care of grounds, security), general administration and general expenses (central offices such as director, office of finance, business services, budget and planning, personnel, general counsel, safety and risk management, management information services).

The applicant may negotiate an indirect cost rate with its federal cognizant agency or state coordinating agency. If there is no assigned agency, TDH's Grants Management Division (GMD) may provide guidance on how to have an agency assigned or TDH's GMD may review the applicant's cost allocation plan and negotiate an approved indirect cost rate. The TDH GMD will maintain a listing of agencies and their approved rates. To obtain information about cognizant agencies or negotiating an indirect cost rate, contact the TDH GMD at (512) 458-7111 ext.2281.

If the applicant does not have an approved indirect cost rate and does not intend to negotiate one, then funds may be budgeted in accordance with Uniform Grant Management Standards (UGMS) which reads as follows:

> "In lieu of determining the actual indirect costs of the service for which a state award is made, a grantee may recover up to 10 percent of the direct salary and wage costs of providing the service (excluding overtime, shift premiums, and fringe benefits) as indirect costs, subject to adequate documentation [of direct salary and wage costs]. Applicants choosing this method of indirect cost recovery are prohibited from seeking recovery using a cost allocation plan, rate or other methods for the same period."

INSTRUCTIONS: Applicant should indicate the indirect cost rate (if applicable) on the BUDGET SUMMARY page and mark the box which contains the appropriate statement regarding the support for the indirect charge. If applicant attaches a copy of the most recently approved indirect cost rate, it should be place behind the OTHER Budget Category Detail Form. If applicant has marked the box "Uniform Grants Management Standards," then an INDIRECT COST Budget Category Detail Form should be completed. The form requires a description of each type of costs and a justification. The justification should include an explanation of the purpose of the services and how it is necessary for the completion of the activity.

FORM H: NONPROFIT BOARD OF DIRECTORS AND EXECUTIVE DIRECTOR ASSURANCES FORM

If the applicant is a nonprofit organization, this form must be completed (state or other governmental agencies are not required to complete this form). The purpose of the form is to inform nonprofit board members and officers of the responsibilities and administrative oversight requirements of nonprofit applicants intending to or contracting with TDH.

_____
_____
_____
_____
(Name & Address Of Organization)

The persons signing on behalf of the above named organization certify that they are duly authorized to sign this Assurances form on behalf of the organization. The undersigned acknowledge and affirm:

A. That an annual budget has been approved for each contract with TDH.

B. The Board of Directors convenes on a regularly scheduled basis (no less than quarterly) to discuss the operations of the organization.

C. Actual revenue and expenses are compared with the approved budget, variances are noted, and corrective action taken as needed (with Board approval).

D. Timely and accurate financial statements are presented by the designated financial officer on a regular basis to the board.

E. That the Board of Directors will ensure that any required financial reports and forms, whether federal or state, are filed on a current and timely basis.

F. Adequate internal controls are in place to ensure fiscal integrity and accountability and to safeguard assets.

G. The Treasurer of the Board has been fully informed of his or her responsibilities as Treasurer.

H. The Board has Audit and/or Finance Committees that convene regularly and communicate effectively with the Board Treasurer and other Board members in understanding and responding to financial developments.

I. The organization observes Generally Accepted Accounting Principles when preparing financial statements and fund accounting practices are observed to ensure integrity among specific contracts or grants.

J. If a contract is executed with the Texas Department of Health, this form will be discussed in detail at the next official Board meeting and that notes of the discussion and a signed copy of this form will be included in the minutes of the meeting. A copy of the minutes will be forwarded to the Texas Department of Health's Grants Management Division, no later than 45 days after the meeting in which the form was discussed.

K. If a contract is executed with the Texas Department of Health and the nonprofit organization has not received any funding from TDH for the past 24 months, the Legal and Fiscal Responsibilities for Nonprofit Board of Directors Video and Guide will be viewed and a signed "tear-out" sheet will be completed and filed by each board member with the nonprofit organization no later than 45 days after contract execution. Newly appointed/elected board members will comply with these requirements no more than 45 days after taking office. All tear-out sheets will be available for inspection by TDH staff.

***Chairman of the Board Signature/Date**

*President or Executive Director Signature/Date

*If the signed original of this form has been provided to the Texas Department of Health during the calendar year and the officers signing the document have not changed, a copy of the signed form will be accepted.

FORM I: HIV CONTRACTOR ASSURANCES

TEXAS DEPARTMENT OF HEALTH
BUREAU OF HIV AND STD PREVENTION

1. ADVOCATE AND PROMOTE

The applicant agency assures that it does not advocate or promote conduct that violates state law, in compliance with the HIV Services Act, Texas Health and Safety Code, Section 85.011, as follows:

> "Grants may not be awarded to an entity or community organization that advocates or promotes conduct that violates state law. This subsection does not prohibit the award of a grant to an entity or community organization that provides accurate information about ways to reduce the risk of exposure to or transmission of HIV."

2. CONFIDENTIALITY

The applicant agency and its employees or subcontractors, if applicable, provide assurance to the Texas Department of Health that confidentiality of all records shall be maintained. No information obtained in connection with the examination, care, or provision of programs or services to any person with HIV shall be disclosed without the individual's consent, except as may be required by law, such as for the reporting of communicable diseases. Information may be disclosed in statistical or other summary form, but only if the identity of the individuals diagnosed or provided care is not disclosed.

We are aware that the Health and Safety Code, §81.103, provides for both civil and criminal penalties against anyone who violates the confidentiality of persons protected under the law. Furthermore, all employees and volunteers who provide direct client care services or handle direct care records wherein they may be informed of a client's HIV status or any other information related to the client's care, are required to sign a statement of confidentiality assuring compliance with the law. An entity that does not adopt a confidentiality policy as required by law is not eligible to receive state funds until the policy is developed and implemented.

3. CONFLICT OF INTEREST

The applicant agency and its employees or subcontractors, if applicable, provide assurance to the Texas Department of Health that no person who is an employee, agent, consultant, officer, board member, or elected or appointed official of this agency, and, therefore, in a position to obtain a financial interest or benefit from an activity, or an interest in any contract, subcontract, or agreement with respect thereto, or the proceeds thereunder, either for himself or herself or for those with whom he or she has family or business ties, during his or her tenure or for one year thereafter shall participate in the decision making process or use inside information with regard to such activity. Furthermore, this agency will adopt procedural rules which require the affected person to withdraw from his or her functions and responsibilities or the decision-making process with respect to the specific assisted activity from which they would derive benefit.

4. TUBERCULOSIS COLLABORATION

The applicant agency assures the TDH that it maintains collaborative efforts with local Tuberculosis (TB) Control programs in order to insure that HIV and TB treatment and prevention services are provided to persons at risk of HIV and TB.

5. DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that it will provide a drug-free workplace in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing a drug-free awareness program to inform employees about-

- (1) The dangers of drug abuse in the workplace;
- (2) The grantee's policy of maintaining a drug-free workplace;
- (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
- (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the

workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will-

(1) Abide by the terms of the statement; and

(2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later that five days after such conviction;

(e) Notifying the agency within ten days after receiving notice under subparagraph (d)(2), above, from an employee or otherwise receiving actual notice of such conviction;

(f) Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), above, with respect to any employee who is so convicted-

(1) Taking appropriate personnel action against such an employee, up to and including termination; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f), above.

6. POLICIES OF THE BUREAU OF HIV & STD PREVENTION

The applicant agency assures the TDH that it will abide by all policies of the Bureau of HIV and STD Prevention which apply to the programs being provided. A list of policies applicable to all HIV and STD contractors is provided at the Bureau website at http://www.tdh.state.tx.us/hivstd/policy/default.htm.

Signature of Authorized Certifying Official	Title
Date	
Legal Name of Applicant Organization	

FORM J: ASSURANCE REGARDING PHARMACY NOTIFICATION

TEXAS DEPARTMENT OF HEALTH
BUREAU OF HIV AND STD PREVENTION

CONTRACTOR ASSURANCE REGARDING PHARMACY NOTIFICATION

To ensure that pharmacies providing prescriptions to HIV services clients do not fill medications on deceased clients, the applicant agency provides assurance to the Texas Department of Health that it will notify the client's pharmacy when a client dies.

Signature of Authorized Certifying Official	Title
Date	
Legal Name of Organization	

FORM K: ASSURANCE REGARDING STANDARDS FOR CLINICAL AND CASE MANAGEMENT SERVICES

TEXAS DEPARTMENT OF HEALTH
BUREAU OF HIV AND STD PREVENTION

Assurance Regarding HIV/STD Clinical Resources Division Standards for Clinical and Case Management Services

This agency assures the Texas Department of Health that it will comply with HIV/STD Clinical Resources Division Standards for Clinical and Case Management Services (Standards) as promulgated by the Bureau of HIV & STD Prevention. The Standards are available at http://www.tdh.state.tx.us/hivstd/clinical/pdf/stvs3_01.pdf

Signature of Authorized Certifying Official	Title
Date	
Legal Name of Organization	